

**KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES**  
**Board of Adult Care Home Administrators**  
**APPLICATION FOR**  
**TEMPORARY Adult Care Home Administrator License**

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**TYPE OF LICENSE**  
**TEMPORARY: \$100.00**

Personal checks are accepted; license may be subject to action if checks are found invalid or insufficient. Visa or MasterCard may be used for payment of fees. Charge authorization form must be completed and signed to utilize this option.

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**Military Considerations**

(For military applicants and spouses - please provide a copy of your United States Uniformed Services Identification Card)

Are you the spouse of an active-duty military service member and wish to receive expedited processing on that basis?

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Are you an active-duty military service member? \_\_\_\_\_

Are you a former military service member? \_\_\_\_\_

If yes, please provide a copy of your DD214 form with Characterization of Service.

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**APPLICANT INFORMATION**

Name: \_\_\_\_\_  
Last First Mi Other

Address: \_\_\_\_\_  
Street / Route / Box / Apt # City State  
Zip

Email: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_

Phone: work \_\_\_\_\_ home \_\_\_\_\_ cell \_\_\_\_\_

*(attach a copy of your Social Security Card or document bearing your name and Social Security number)*

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**FACILITY IN WHICH YOU ARE SEEKING EMPLOYMENT:**

Facility Name: \_\_\_\_\_ Facility Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_  
Street / Route / Box / Apt # City State Zip

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**EDUCATION - List**

College/University

Degree

Date Conferred

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

If applicable, transcripts must be sent by the college or university directly to Health Occupations Credentialing. If you are filing for testing under KSA-65-3504(b), request, complete, and submit Application for Exemption of Formal Education.

**FUTURE PLANS**

I will seek full licensure.

**Y / N**

I will plan to seek licensure based on licensure in another state.

**Y / N**

I have held a license as a Kansas Adult Care Home Administrator.

**Y / N**

If YES, License Number: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

I have at least once failed the examination specified in KAR 26-38-4. **Y / N** Exam Date: \_\_\_\_\_**LICENSE IN ANOTHER STATE**

List all states in which you have ever held an adult care home administrator license:

State: \_\_\_\_\_ State: \_\_\_\_\_ State: \_\_\_\_\_

State: \_\_\_\_\_ State: \_\_\_\_\_ State: \_\_\_\_\_

For each state, complete Part I of the verification of license, request that the state Board complete Part II and return verification to this Board

**DOCUMENTATION OF NEED FOR TEMPORARY LICENSE**

K.A.R. 26-38-6 requires that applicants provide written documentation from the board of directors, corporation or ownership of the facility that no licensed, qualified applicant is available to serve as administrator in the facility and written endorsement that the applicant is the most qualified applicant for the facility where the person is to be employed.

**Disciplinary Action**

If you answer yes to any misdemeanor/felony/disciplinary question(s) on the application the required documentation must be received by this Board, or your application will be considered incomplete and cannot be processed. If you have questions about the conviction or disciplinary action requirements, please contact Wendy Jacobs at 785.296.0061 or wendy.jacobs@ks.gov. Review the information for an explanation regarding the documentation that must be submitted if you answer "yes" to any of the following questions.

Have you ever been convicted of a felony? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Have you ever been convicted of a Class A misdemeanor?  
(any crimes as listed in K.A.R.26-38-5) **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Have you had a judgement of settlement in civil record?  
(as described in K.A.R. 26-38-5) **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Do you have any pending criminal case against you for a felony or Class A misdemeanor offense? **Yes** \_\_\_\_ **No** \_\_\_\_

Do you presently have any physical or mental conditions or use of drugs or alcohol that could affect your ability to competently and safely practice as an Administrator of record for an Adult Care Home? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
(if yes, submit an explanatory letter and physician's release)

Has disciplinary action ever been taken against an adult care home administrator license, a professional or occupational

health care license, a mental health care license or a social worker license held by you, whether issued by this state or another state or jurisdiction?

Yes \_\_\_\_\_ No \_\_\_\_\_

**(If yes, please provide specific details and copies of all relevant documents.)**

Have you ever had an Adult Care Home Administrator license denied, revoked, limited, suspended, or publicly or privately censured by a licensing authority? Yes \_\_\_\_\_ No \_\_\_\_\_

**(If yes, please provide specific details and copies of all relevant documents.)**

Are you registered, certified, or licensed in any other profession? Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes, please list:** \_\_\_\_\_

Have you ever voluntarily surrendered any professional license while an investigation or discipline case was pending?

Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever allowed any professional license to expire while an investigation or discipline was pending? Yes \_\_\_\_ No \_\_\_\_

Do you have any pending investigations or disciplinary cases against you or your license, certification, or registration by a professional licensing authority? Yes \_\_\_\_\_ No \_\_\_\_\_

**NOTE:** Pursuant to state regulations, the Board requires that you provide all reports and court documents related to the conviction. Materials should be submitted to Health Occupations Credentialing. Please note, any and all costs for obtaining such reports/documents are your responsibility. You are also invited to submit a letter and any other additional supporting information or documents to the Board explaining the circumstances surrounding the case, complete resolution of the issue (including final probation, community corrections or parole documents), and how/why this situation is not expected to occur again. The candidate shall have the burden of proving that the candidate has been rehabilitated and warrants the public trust.

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I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the Board to verify any information provided in this application and attachments. I understand that the application fee is non-refundable should I not meet licensure qualifications.

I declare under penalty of perjury under the laws of the State of Kansas that the information provided above is true and correct to the best of my knowledge.

**Signature:** \_\_\_\_\_ Executed on: \_\_\_\_\_  
(date)

Submit application, fee and supporting documents to:  
**Health Occupations Credentialing**  
**Kansas Department for Aging and Disability Services**  
**503 S Kansas Ave, Suite 300C**  
**Topeka, Kansas 66603-3404**